HOSPICE Management ADVISOR™

Integration • Outcomes • Managed Care • Medicare Compliance • Risk Management • QI • End-of-Life Care

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

JANUARY 2004
VOL. 9, NO. 1 • (pages 1-12)

Florida offers a model for improving clergy training in end-of-life care

Clergy get practical help in dealing with EOL issues

A cornerstone of quality end-of-life care is its attention to matters of the spirit. In recognition of this, hospices have offered spiritual care as one of their core services. Still, clergy in the community who support members of their congregations in times of need are often armed only with good intentions when it comes to care for the dying.

There is an almost unquestioned assumption that clergy are equipped to deal with matters of death and dying. That assumption is a dangerous one, says clergyman **Kenneth Doka**, PhD, professor at the College of New Rochelle (NY) and a senior consultant to the Hospice Foundation of America.

"Often, [clergy] are clearly uncomfortable with handling death and dying issues, but in crisis ministry, that's where you establish your credibility," says Doka.

Although hospices recognize clergy as partners in caring for patients and their families, they also know that some clergy are more informed than others when it comes to end-of-life care. Traditionally, clergy members of all faiths and denominations receive little or no formal training in advising, assisting, and supporting people through end-of-life crises, according to the Clergy End-of-Life Education Project, a state-funded initiative in Florida that is seeking to educate clergy in end-of-life care. Members of the clergy often are called on to minister to the dying and their families, offering counsel and support at moments of trauma and loss. Even today, many theological schools provide little or no instruction in grief and bereavement.

"Outside of family and friends, in a health crisis, who are people going to call upon?" Doka says. "Their physician and clergy."

As it turns out, clergy are no different from most people when it comes to end-of-life issues. For clergy to become partners in the movement to improve end-of-life care, hospices must help clergy become

more familiar with the principles of end-of-life care. The Clergy End-of-Life Project in Florida serves as an example of how to involve all stakeholders in improving end-of-life care.

The program's goal was to help clergy members better address end-of-life issues by educating them about bereavement and options for care at the end of life. Empowered with that information, clergy can minister more effectively to the dying and their families.

The statewide project was implemented in 13 counties throughout the state and included an extensive curriculum that addressed key issues in end-of-life care, a tool kit of consumer information, and statewide educational workshops for clergy members. Leaders of the project included representatives from hospice, university ethics and gerontology programs, clergy members, and medical care providers.

The Clergy End-of-Life Education Project was funded by the Florida Legislature and administered through the Department of Elder Affairs for the contract period July 1, 2002 through June 30, 2003. The Hospice Foundation of America (HFA) was designated as the lead agency. Its total funding for the year was $262,500.

According to Doka, who served on the Project's advisory committee, the project is a good example of how the hospice industry can educate one of its most important partners. One of the strengths of the program, he says, is the ease with which it can be replicated in other parts of the country.

Developing a program

The goal of the program was to develop a curriculum that provided practical knowledge. Project developers adopted three forms of education material:

- resource material;
- consumer material;
- training modules.

The HFA provided the lion's share of resource material. The clergy resource materials consisted of complimentary copies of HFA's audio tape set *Clergy to Clergy: Helping Clergy Minister to Families Confronting Illness, Death and Grief*, and the books *Caregiving and Loss* and an additional book selection from the HFA *Living with Grief* series. The *Clergy to Clergy* series includes lectures and discussions on the following topics:

- "Counseling Those with Life-Threatening Illness";
- "The Funeral Ritual, Empowering Healing";
- "When a Child Dies";
- "Facing Illness as a Family";
- "What is Grief?";
- "Complicated Mourning."

A packet including the six tapes and the accompanying resource guide was given to each clergy member who attended the sessions. The packet also included books in an HFA-published series called *Living with Grief*. The series included:

- *Living with Grief: Loss in Later Life* (2002);
- *Living with Grief: After Sudden Loss* (1996);
- *Living with Grief: When Illness is Prolonged* (1997);
- *Living with Grief: Who We Are, How We Grieve* (1998);
- *Living with Grief: At Work, At School, At Worship* (1999).

Another aspect of the program was the creation of consumer-oriented educational materials that clergy could give to the families to whom

Hospice Management Advisor™ (ISSN# 1087-0288) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. First-class postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospice Management Advisor™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). **Hours**: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), $349. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $209 per year; 10 to 20 additional copies, $140 per year. For more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $58 each. (GST registration number R128870672.)

Editor: **Eric Resultan**, (770) 329-9684, (eric_resultan@msn.com).
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@thomson.com).
Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@thomson.com).
Production Editor: **Brent Winter**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

they minister. The materials were produced by culling available information that could be adapted into easily readable material.

The consumer materials consisted of information on advance care planning, dealing with end-of-life care options, and undergoing grief and bereavement after the loss of a loved one. Workshop participants were told that these materials could be reproduced and disseminated to members of their respective faith communities. The consumer packet included the following:

- "The Medical Futility Guidelines of South Florida — A Guide for Patients and Their Families, Health Care Surrogates, or Proxies";
- Florida "do not resuscitate" order;
- "What You Should Know About Advance Directives";
- Florida living will;
- Florida designation of a health care surrogate;
- "When Someone You Love Dies";
- "How to Talk About End-of-Life Concerns";
- "Helping a Child Deal with Loss";
- Web-based resources;
- End-of-Life care resources (by county);
- glossary of end-of-life terms.

At the regional education sessions, each clergy participant received three folders containing the consumer materials. In all, 3,000 packages of the consumer materials were distributed at the sessions. A total of 70,000 pieces of material for distribution to families were duplicated, the final report on the project indicated.

Training curriculum materials

Perhaps the centerpiece of the project was its seven-module Trainer's Manual and accompanying Participant's Manual. The development of the manual and training objectives were determined by an advisory committee, which determined the training sessions would be done in a one-day workshop format (approximately six instructional hours) with the option to do half-day sessions to meet local preferences.

The overall learning objectives were defined as follows:

- to provide an understanding of the physical and psychological changes brought about by the dying process;
- to enhance clergy members' ability to provide assistance to families facing the dying process;
- to provide an understanding of the advance care planning process and the care options available to people with terminal illnesses;
- to enhance the understanding of clergy regarding the grieving process;
- to support clergy in fulfilling their role in providing spiritual care at the end of life;
- to increase the clergy's sensitivity to the need for self-care.

The seven modules included the following:

Module 1. Cultural Considerations at the End of Life
Module 2. The Dying Process
A. Medical Issues
B. Psychological Issues
Module 3. End-of-Life Options
A. Advance Care Planning
B. Service Options
Module 4. The Grief Process
A. Typical Grief Reactions
B. Complicated Grief
C. Anticipatory Grief
Module 5. Assisting Families
Module 6. The Role of Spiritual Care
Module 7. Self-Care for Clergy

To provide flexibility at the local level, the Trainer's Manual included additional text material for review and use by the regional trainers. The content of the material in each module included more than could be presented in the time allotted to the subject matter so trainers could select those key points they wanted to emphasize.

Lessons learned

In the end, program developers seemed pleased with their results. In their final report, project officials said, "The curriculum received high scores for comprehensiveness by participants. When asked what else they would like to have included, they responded 'more of the same,'" the report said. "There are parts that would benefit from further development . . . but the concepts of the program have proven their worth and relevance to the target audience."

Specifically, the project officials said the following issues could expanded:

- **Self-care:** Participants wanted to see more training on dealing with their own stress.
- **Cultural issues:** Attending clergy noted that more attention could have been paid to cultural issues, such as how these issues can affect the quality of their counseling. The final report noted that future programs should include other ethnic groups.
- **Spiritual issues:** Participants wanted the program to provide time and space for exploration of

their own spiritual beliefs regarding death and dying.

The final report noted that the advisory committee wanted to convey the importance of cultural and ethical considerations in end-of-life decisions. "When we approached the subject, it became clear that we could not address all the many cultures that comprise Florida's population," the report said. "The determination was made to provide material that addressed cultural sensitivity in a general sense, and not specific cultural practices." ■

Hospice Trends

Good marketing requires good management

Buy-in at the top levels is needed

By **Eric Resultan**
Editor, *Hospice Management Advisor*

Sometime last year I was having a conversation with a hospice marketing director about the stalled growth of the marketing director's hospice. We were discussing how a marketing plan would benefit the hospice. The marketing director agreed that based on trends in the hospice's metropolitan market, there were opportunities for the hospice to increase its market share. In particular, the marketing director said nursing homes, especially those outside the hospice's traditional geographic area, were an untapped revenue source.

The problem, however, was that an influential member of the hospice's management team didn't agree, and no matter what evidence the marketing department would have gathered to prove its case, the income potential of nursing homes was a dead issue.

That's right; a marketing plan was DOA before the process of creating one (or amending the current plan) even got started. Now stop and think for a moment: Were you that manager? As a leader of your organization, do you see your marketing director as an influential member of your management team, or is your marketing director someone who merely follows up with physicians and other referral sources? Is your marketing plan synchronized with your daily operations, or is it separate from the overall direction in which your hospice is going?

If you gave the latter answer for any of these questions, you may be the problem, not your marketing plan. In order for marketing plans to work, hospice leaders must accept the following principles, or doom their plan to failure:

• Top management must be committed to the process.

A hospice can have the most brilliant marketing strategist money can hire, but unless CEOs, CFOs, and the board of directors buy into the process, there will be little support for the strategist's findings and recommendations.

Embarking on a new marketing plan or a revision of a previous one has the potential to turn an organization on its head. Market data collected in preparation for brainstorming sessions could shed new light or cause some to look at the organization in completely different way. In a word, a new marketing plan can suggest "change."

Organizational change is not a grass-roots process. Committing to a marketing plan at the highest level is an endorsement of change that will trickle down to the rest of the organization.

• The CEO is the chief strategist.

The belief that change is inevitable must not only be accepted but actively embraced by a hospice's leader. This is what it takes to develop a strategic mindset, one that will guide the decision-making process throughout market plan development and will promote a willingness to adapt to the changing marketplace. This doesn't mean radical change is the only way to grow an organization. But even if the CEO and hospice leaders choose a conservative marketing approach, that decision should be based on an analysis that examines a number of options, including radical change.

As the chief strategist, the CEO must buy into the following ideas:

— Change is inevitable.

— If the hospice must find a better way, the competition will also find it.

— The organization's future should be determined by the marketplace, not by what seems logical to the CEO.

— Market share is a good indicator of your organization's development.

— The hospice should seek out competitive advantages in everything it does (fastest response to referrals, most supportive medical and clinical staff for referring physicians, etc.).

— There is room to grow in the current market, but hospice management must be willing to diversify outside the hospice's primary business (i.e., concurrent care vs. traditional admissions).

• The marketing plan must be a way of life, not an exercise.

Whether your organization is developing its first marketing plan or reviewing and amending an annual marketing plan, what you do with that plan makes all the difference. The plan must be integrated into the organization's business plan, complete with determined actions and goals. For example, if an analysis of a hospice market reveals that physician referrals from a particular specialty are lower than in previous years, the plan may include the need to address this trend. You may decide you to increase education efforts and build relationships in those areas. Yet, unless that action is tied to the tasks that are performed each day, the plan will falter. In this instance, the action must be made part of someone's job, complete with rewards or consequences attached to completion of the action.

A marketing plan is only as good as its execution. If it sits on a shelf waiting for review and amendments next year, it's likely the plan has not permeated the organization.

• The hospice's marketing approach must be balanced and integrative.

To achieve the goal of making a plan part of the organization's way of life, the marketing plan must be integrated into the organization. This includes integration with finance, personnel, and operations functions.

Another aspect of integration is examining how a marketing plan relates to other plans within the organization. For example, an organization's business plan may contradict or compete with the marketing plan. The exercise of integration will determine whether a marketing plan will have to be revised or rejected in order to achieve organizational harmony. An integrated marketing plan should ultimately complement the functions mentioned above.

• There must be detailed goals.

It is not enough for a marketing plan to say there needs to be an increase in referrals among hospitals outside the city limits. The development of a marketing plan must include detailed goals. For instance, a specific percentage increase in referrals from each of the hospitals outside the city should be part of the plan.

Goals represent the benchmarks an organization is trying to achieve. It is important to establish goals that are measurable, such as market share, the number of referrals, patients served, etc.

• There must be an action plan.

For each goal there must be a results-oriented action plan. An action plan is the map to achieving your goals. Consider how you expect to achieve the goals you have set for your organization and what results you expect these actions to yield. If, for example, your goal is to increase referrals among cardiology groups by 15%, your action plan for this goal may include a multi-pronged approach that includes cardiology-specific hospice education material, small-group luncheons, increased medical director support, and consultations to these physicians. In addition, plans have to be monitored to determine whether they are progressing as expected. You may even attach incremental goals to monitor the progress of an action plan. ■

Determine your needs before the first interview

Plan ahead to find nurses who will stick with you

"Fire any manager who invents a new form" was one of the written responses to a survey of nurses conducted by the Bernard Hodes Group, a human resources company based in New York City. (For a copy of the full survey, go to www.hodes.com/hcrecruiting.)

Unfortunately for home health, a seemingly uncontrolled proliferation of new forms and additional paperwork creates one of the greatest obstacles to recruiting experienced nurses to home health, say experts.

While there are many positive aspects of home health nursing that help in recruitment, the increasing paperwork required by regulatory and reimbursement organizations is detrimental, says **Coleen Conway-Svec**, RN, MS, MBA, chief operating officer of the Visiting Nurse Association of Southeast Michigan in Oak Park. "Home health agencies have a better product to offer nurses than hospitals because we can offer positions that

require independent decision making, flexible schedules, and an opportunity to develop a relationship with a patient," she says. "Unfortunately, the amount and detail of the paperwork required chases nurses away."

"One of our top priorities is to use technology to diminish the paperwork burden on our nurses," says **Don Richardson**, vice president of administration for the Visiting Nurse Association (VNA) of Texas in Dallas. "We are not automated at this time, but we are looking at automation of all of our forms," he says. "We are in a very competitive environment, with hospitals being our primary competition for nurses."

Hospitals tend to be Richardson's biggest competitors for experienced nurses because the VNA of Texas pays registered nurses a salary rather than based on visits, he says. "Other home health agencies in the area pay based on visits, so a nurse that wants to go into home health finds our agency's pay policy more attractive," he adds. "Unfortunately, this also means that the home health agency has to deal with local hospitals' escalating salaries in order to compete."

Salary and benefits are not an issue for Conway-Svec's agency, but she has had to address other issues to reach her goal of being fully staffed with RNs and having a few extra on board to handle growth, she says. "We have addressed the paperwork issue with all full-time field nurses having laptops," she points out. "They are able to complete the OASIS [Outcome and Assessment Information Set] forms and transmit them directly to the office without having to use paper."

The VNA of Southeast Michigan has not always enjoyed a full nursing staff. "Less than two years ago, we typically had a 30% vacancy rate, with tenure for new hires averaging six months," Conway-Svec points out. Even with the use of technology to automate paperwork, one of the most frequently cited reasons for nurses leaving after such a short time was that they didn't realize how much documentation was required, she says.

"We realized that we weren't painting a good picture of the job during the interview and hiring process," she explains. This realization led to the development of a new way to interview qualified applicants that enables the job applicant to see what is entailed in home health nursing while also giving the agency a chance to more fully evaluate the applicant's qualifications for home health.

"Our applicant shadowing program allows a job applicant to spend half of a day with a field nurse making visits," explains Conway-Svec. **(See description of shadowing program, p. 8.)** "We pay the applicant to spend about four hours with one of our more experienced nurses, riding with the nurse to see patients," she says. While the job applicant doesn't participate in provision of care, he or she does see the type of care, education, and documentation required during a home health visit, she adds. Not only does the applicant get an accurate impression of what home health is, but the field nurse has the opportunity to answer questions that may occur to the applicant after seeing a visit, she says. "The field nurse also has a chance to form an opinion of how well-suited the applicant may be to home health," she adds.

Address feelings of isolation

While use of laptop computers has made the nurse's job more efficient and has reduced the driving required to come into the office to pick up visit schedules and turn in paperwork, the technology also has increased the feeling of isolation, another risk to retention of home health nurses, especially new hires, Conway-Svec notes.

Although the independence and autonomy of home health visits appeals to nurses who enjoy making decisions and working on their own, the technology that has removed the need to go into the office also has increased the isolation a field nurse may feel, she says. "We didn't consider how this isolation would affect the team spirit of our staff when we began using laptops."

To address the lack of face-to-face time, Conway-Svec's agency has developed a more structured continuing education program in which nurses must come to monthly courses. "We build time into each of these programs for networking, visiting with peers or managers, and sharing information or concerns," she adds. Managers and supervisors also stay in contact with staff members by voice mail or e-mail so questions can be answered quickly and concerns identified before the nurse is overwhelmed, she explains.

Once you've addressed your agency's paperwork, salary, or isolation issues, it's important to make sure you use the right techniques to attract nurses, Richardson adds. "We go through cycles when we are short-handed and need to recruit heavily, and then other times, we are fully staffed."

Vary recruitment efforts to improve hiring process

Show applicants you respect their time

There is no magic formula for attracting the best applicants to your agency, but using a combination of marketing tools to reach nurses with news of job openings will help you find the people you want, according to **Don Richardson**, vice president of administration for the Visiting Nurse Association of Texas in Dallas.

His agency uses a combination of newspaper and periodical advertising, job fairs, referral bonuses, on-line recruitment, and direct mail to reach potential employees. "It's important to vary your recruitment efforts so your approach stays fresh and so you can evaluate which method works," Richardson points out.

The referral bonus, for example, is always run as a short program, usually 60 days in length, during which employees get a cash bonus for referring a candidate who is hired, he says. "The referral program is not a huge success that always results in a lot of job applicants, but it is another tool for us to use, and the applicants we get through referrals from other employees are always appropriate in terms of experience and skills," he says.

Your print advertising also should be evaluated on a continuing basis, says **Coleen Conway-Svec**, RN, MS, MBA, chief operating officer of the Visiting Nurse Association of Southeast Michigan in Oak Park. Although she isn't spending any more money on advertising than she did two years ago, her ads are more effective after a redesign in which more white space and graphics were added to make the ad stand out among other help-wanted ads, she says. "The new ads get more attention, and we get plenty of qualified applicants when we run them," she says.

Once someone responds to the advertisement, be sure you present the right message, Richardson adds. "You must make the job applicant feel like you really want them. When a job applicant comes into our office, we roll out the red carpet and make sure they know that we think they are important," he explains.

"We greet them as soon as they come into the office, we don't leave them sitting in the waiting area for a long time, and we show them that we respect their time and their interest in our agency." These efforts do pay off, he says. "This is the way we want our nurses to treat our patients, so we need to treat them in the same manner when we first meet them as applicants." ■

Depending on the agency's need for staff, he uses a combination of print advertisements in newspapers or other periodicals, on-line recruitment, job fairs, direct mail, and referral bonuses for current employees. **(For more on advertising efforts, see story above.)**

Another key to identifying problems in recruitment or hiring is the exit interview, Richardson points out. While most agencies do conduct exit interviews, Richardson handles some employees' exit interviews a little differently than normal. "Sometimes an employee is angry when they are leaving and their emotions may not enable them to give you an accurate explanation of the reasons for their leaving," he says. For this reason, he waits a month or two, then mails a written survey that asks them to give their opinion of the agency and explain their decision to leave. This cooling-off period results in a truer evaluation of the agency and more opportunities for improvement, he adds.

Perhaps the most important thing an agency can do to make sure recruitment and interviewing practices are resulting in the best hires is to track vacancy rates each month, suggests Conway-Svec.

"I came to home health from hospital nursing administration, where we always thought in terms of full-time equivalents [FTEs] and noted open positions more easily. Because our agency pays on a per-visit basis, there is less emphasis on FTEs," she explains. As long as visits are made, it is hard to see potential problems with a shortage of staff.

To make sure managers and supervisors stay on top of keeping positions filled, the agency runs a monthly report that lists vacancies and the length of time it takes to fill them, Conway-Svec says. "If we can see trends that indicate a problem with our recruitment practices or problems in retaining new hires, we can look for solutions." ■

To hire better, show applicants the job

Getting away from the 'warm body' philosophy

It took about 18 months of hard work, but staff at the Visiting Nurse Association (VNA) of Southeast Michigan in Oak Park found the solution to a recruitment and retention problem that made the agency look like a revolving door for registered nurses.

With a vacancy rate of 30% and a new hire tenure of only six months, agency managers and supervisors were constantly recruiting, interviewing, and hiring new nurses, says **Coleen Conway-Svec**, RN, MS, MBA, chief operating officer of the agency.

"It was obvious that we were not hiring the right people for our field nurse positions, so phase one of our plan to address vacancies was to describe who we wanted to hire," she explains.

Interview includes behavioral component

Nurse managers worked together to develop a profile of a successful hire. "To build the profile, we looked at the qualities and attributes of our best nurses, added the skills needed for our patient population, and defined the experience necessary to work independently," Conway-Svec explains. Along with the profile, the managers developed a behavioral interview guide that includes questions that go beyond having the applicant list skills, education, and experience. Behavioral interview questions ask the applicant to describe how he or she would handle certain situations.

It's important to learn during the interview whether the applicant has customer service skills and can be compatible with other team members, points out **Don Richardson**, vice president of administration for the VNA of Texas in Dallas. "While an individualized training program can address weaknesses in certain skills, it's harder to teach the ability to develop a relationship with a patient or to work as a team in home health," he explains.

After pulling together a profile and interview guide, the second phase of VNA of Southeast Michigan's new hiring program involved development of an "applicant shadow" program, in which an applicant spends a half-day in the field with a nurse. "Our new hires who were leaving within six months were saying they had no idea how lonely they would be or how much paperwork they would have to complete," Conway-Svec says. "We decided the best way to describe their potential job to them was to take applicants we were seriously considering on patient visits," she adds.

With the consent of the patients, the applicant accompanies a "nurse ambassador" on his or her visits. The applicant is paid for four hours to ride with the ambassador, observe the visits, and ask questions of the ambassador during the half-day.

Nurse ambassadors provide good feedback

"Our nurse ambassadors are hand-picked, experienced nurses who receive about eight hours of training for the program," Conway-Svec continues. Their training includes a review of the agency's mission, values, programs, and services. "They also spend time learning how to handle tough questions from applicants in a positive manner."

This approach to hiring has a number of benefits that were not expected, she admits. "Bringing field nurses in as ambassadors has created a new group of staff members beyond supervisors and managers who have a sense of ownership and a stake in the success of our hiring program.

"We also have an opportunity, through the ambassadors, to observe the applicant in a typical home health setting and judge whether or not the applicant will be a good fit," Conway-Svec adds. In addition to the results of interviews with supervisors and managers, the ambassadors' feedback is taken into account when evaluating an applicant. "Many times the ambassadors will intuitively know whether or not the person will make a good home health nurse, and we trust their judgment."

Within nine months of implementing the new interview process and the applicant shadow program, all positions were filled, and the agency now enjoys a low turnover rate, says Conway-Svec. "Our turnover rate for new hires within the first six months is only 4%," she says proudly.

VNA of Southeast Michigan has experienced this success as a result of improving the process of finding the right person for the job, says Conway-Svec. "We no longer have a 'warm body' philosophy in which we just hire anyone," she explains. "We make sure the hire is right for both the agency and the applicant." ■

Do sacred cows still graze in your agency?

Evaluate rituals with eye to profitability, efficiency

They still graze in and around your agency, but an increasing number of home health managers are starting to look critically at "sacred cows" that need to be put out to pasture.

Sacred cows are rituals, beliefs, or guidelines that are routinely followed without anyone really questioning the origin or even the appropriateness of the belief.

"The home health industry is even more reluctant to let go of some practices than other home care-related industries, such as infusion or durable medical equipment," says **Dexter Braff**, MBA, MS, president of The Braff Group, a health care mergers and acquisitions firm in Pittsburgh. "The fundamental difference between home health and the other two industries is that home health grew under a cost-based reimbursement plan," he says. "As a result, home health managers and staff members developed a way of doing business that fostered an attitude that is still hard to shake."

Don't be uncomfortable with profit

The first and most obvious sacred cow for home health is the belief that profit is a dirty word, Braff says. "As an industry, home health representatives are embarrassed to talk about profits, as if making a profit equates to giving low-quality service," he says. In fact, under the cost-based reimbursement system, many extra costs were generated in the name of quality when the reality was that extra services did not always translate to extra quality, he adds. "Today, people are still receiving quality care, even though agencies are having to find innovative ways to become more efficient," he explains.

"Even if you are a not-for-profit agency, you still need to generate profits to continue providing services and have a reason to be in business," points out Braff. Managers who are uncomfortable with the idea of generating profits can think of the profit as a surplus that can be used to provide services to other patients, he suggests.

The best way to overcome the idea that profit is a dirty word is to run monthly financial statements in which you can see the earnings you generate, your contribution to the organization's bottom line, and the surplus you provide to support not-for-profit or free services to underserved patients, Braff recommends. "If your agency is not making money, you are not operating efficiently, and you need to evaluate changes that will improve your efficiency," he says.

"The idea that we can protect ourselves from the risk of decreasing Medicare reimbursement by going into private duty is another belief that may or may not be right for your agency," says Braff. "While private duty is a good business strategy for some, it is very difficult to succeed when you offer both Medicare and private-duty services," he says.

Although it seems to make sense to say that resources can be used for both sides of the business, this is not the case, Braff points out. "You use different types of caregivers and different billing systems, so you can't blend all services," he says. "It's the same with agencies that believe the same staff can be used to provide hospice, pediatric, and private-duty services," he adds. "You have specialized nursing for hospice, geriatric, and pediatric patients, so you aren't saving on staff costs because you still need the specialists," he explains.

Another cow that needs to be pastured is the idea that home health agencies can reap the benefits of economy of scale as they add new patients, Braff says. "The economy-of-scale theory works well in many industries, but not in home health, because there are virtually no fixed costs in home health," he points out.

Keep track of step-variable costs

"Agency managers misidentify costs by assuming that administration, billing, and nurse supervisors are fixed costs," he says. "In reality, they are step-variable costs, which means that I don't need to add another billing clerk or another nurse supervisor for one new patient, but I will need to for 100 new patients," he explains.

For this reason, managers need to know exactly where they will need to increase resources when adding new patients so they can accurately predict costs and profits, Braff says.

"This is especially critical for agencies that negotiate managed care contracts," he adds. "If a new contract might mean 100 new patients, be sure that you know exactly how much you will have to spend to care for those patients before you sign the contract and agree to a price that

leaves you no margin for profit," he says.

"Another leftover belief from the days of cost-based reimbursement is that some home health managers are reluctant to invest in technology for which the government doesn't pay," Braff says. While many agency managers see the importance of technology, they are not ready to make the leap, he adds. The most effective technology for agency managers to consider is anything that cuts down on processing information, automates OASIS (Outcome Assessment and Information Set) reporting, or decreases the amount of time to get the initial request for anticipated payment (RAP), he says.

Hand-held computers preferred to laptops

"We cut our administrative costs by 30% because we didn't have to input the data from paper forms, we reduced the mileage reimbursement for our nurses because they didn't have to return to the office each day, and our cash flow improved because we cut 15 days off the time it took to receive our RAP," says **Mark O'Brien**, owner of Texas Senior Care in Dallas. He's describing the results of automating his agency with hand-held computers for all of his field nurses.

"We chose hand-held computers rather than laptops because they are very inexpensive and don't require a staff person to maintain them," says O'Brien. "They are much easier for nurses to carry, especially when climbing stairs and carrying other supplies," he adds.

"Not only are the forms legible, but the software doesn't allow conflicting information to be entered on the OASIS form," says O'Brien. "For example, if a nurse indicates that the patient can be taught to perform certain care activities, then later describes the patient as having dementia, the software does not enable the nurse to proceed until the inconsistency is resolved," he says. This inconsistency is a mistake that would delay payment while the mistake was identified and resolved with paper forms, he says.

While home health employees tend to be more motivated by caring for people rather than making money, home health currently is undergoing a shift in that regard, with more business-oriented people taking management positions, Braff adds.

"We now look at home health not as a clinical service, but as a business that provides clinical service," he says. ■

News From the End of Life

Study: Caregivers suffer long-term effects of stress

Caregivers' IL-6 levels were four times higher

A study of caregivers suggest that the effects of chronic stress resulting from caring for a dying family member may last for years.

As part of a long-term study examining stress and health in older caregivers, scientists at The Ohio State University in Columbus followed 119 women and men who cared for spouses with dementia, along with a similar number of age-matched non-caregivers. The subjects gave regular blood samples and answered questions about stress, depression, and loneliness.

The findings, published in the July 2, 2003, *Proceedings of the National Academy of Sciences Online*, focus on interleukin-6 (IL-6), a compound that circulates in the blood and helps regulate the immune system. Excess IL-6 plays a role in muscle atrophy and several diseases of aging. It promotes the production of C-reactive protein (CRP), a risk factor for cardiovascular disease. Both IL-6 and CRP are implicated in type 2 diabetes, osteoporosis, and arthritis.

Stress has lasting impact on immune system

Scientists have begun to recognize some health risks associated with caregiving. Compared with non-caregivers, caregiving spouses have more depression, hypertension, infectious illness, and heart disease. They're also at greater risk for early death.

Researchers said they located an immune system pathway that links caregiver stress to serious health problems. This mechanism apparently remains active even years after the stress is gone. The findings contribute to scientific understanding of how stress can make people sick and why stress reduction may be a lifesaver.

On average, the caregivers in the study had four times as much IL-6 in their blood as the non-caregivers — an effect that continued for several years after the spouse had died. According to the researchers, this suggests that chronic stress may have a lasting impact on the immune system. ▼

New neuropathic pain guidelines published

Guidelines recommend lidocaine patch

New pain management guidelines for treating patients with chronic neuropathic pain were published in the November issue of *Archives of Neurology* (2003; 60:1,524-1,534). The evidence-based guidelines are designed to help physicians better diagnose and manage patients suffering from chronic neuropathic pain.

According to the report, these guidelines are significant because they review recent studies and provide physicians with recommendations on specific therapies as first-line treatment.

Therapies recommended as first-line agents for the treatment of neuropathic pain include lidocaine patch 5%, gabapentin, opioid analgesics, tramadol, and tricyclic antidepressants. Endo Pharmaceuticals' Lidoderm (lidocaine patch 5%), a topical treatment that targets the site of the pain, rather than the entire body, was the first drug approved by the Food and Drug Administration (FDA) for post-therapeutic neuralgia and is the only topical treatment recommended as a first-line therapy in these guidelines.

The FDA-approved dosing for the Lidoderm patch is up to three patches applied for up to 12 hours within a 24-hour period. The patch has not been approved by the FDA for any indications other than for the relief of pain associated with postherpetic neuralgia, and its safety and efficacy in other indications have not been established. ▼

Study shows caregivers overestimate pain

Caregivers need training in pain assessment

A study conducted by the College of Nursing at the University of South Florida in Tampa shows that caregivers often overestimate their sick family member's pain.[1]

As health care increasingly moves out of hospitals, care of patients with cancer is more often provided in the community with the help of family caregivers. In many cases, nurses depend on family caregivers to provide assessment data about patients. This makes the accuracy and dependability of the data given by caregivers particularly important.

The study included 264 newly admitted adult patients with advanced cancer in hospice home care and their primary caregivers. Patients and caregivers completed questionnaires that included numeric rating scales for pain, dyspnea, and the Constipation Assessment Scale. All of these scales were designed to describe the patient's symptom intensity. The results indicated that caregivers significantly overestimated symptom intensity for all three symptoms.

Results of the study indicate that hospice and home health nurses need to train caregivers in conducting systematic assessments of pain instead of assuming that they understand the patient's symptoms. Until then, nurses need to be wary of relying upon family caregiver reports of pain.

Reference

1. McMillan SC, Moody LE. Hospice patient and caregiver congruence in reporting patients' symptom intensity. *Cancer Nurs* 2003; 26:113-118. ▼

RWJF announces funding of leadership centers

Six institutions to provide palliative care training

The Center to Advance Palliative Care (CAPC), a national program of The Robert Wood Johnson Foundation (RWJF), has announced that RWJF is committing $4.5 million to increase the availability of palliative care in hospitals throughout the nation.

The grants will fund six institutions with exemplary palliative care programs — Palliative Care Leadership Centers (PCLCs) — over a three-year period. Each will provide a site-visitor program for professionals from other health care institutions intending to start palliative care programs. PCLCs will offer hands-on intensive training focused on the financial and operational aspects of building a program.

"The PCLC initiative will help millions of patients and families who suffer from the pain and debilitating symptoms of serious, chronic illness. Palliative care is a rapidly growing trend, and over 800 hospitals now have palliative care

programs. However, a disparity still exists between the number of U.S. hospitals (approximately 4,500) and the number hospitals with palliative care programs," says **Diane E. Meier**, director of the CAPC in New York City.

RWJF and CAPC solicited proposals from palliative care programs throughout the country. The Palliative Care Leadership Centers are:

- Fairview Foundation (Fairview Health Services), Minneapolis;
- Massey Cancer Center of Virginia Commonwealth University Health System, Richmond;
- Medical College of Wisconsin, Milwaukee;
- Mount Carmel Health System, Columbus, OH;
- Palliative Care Center of the Bluegrass, Lexington, KY;
- University of California, San Francisco. ▼

CMS rolls out its quality initiative

Home Health Compare, the Centers for Medicare and Medicaid Services' (CMS) national quality initiative for home health agencies became active, took effect in November.

Home Health Compare's pilot test began in May 2003, and includes outcomes data on items that include improvement in ambulation, improvement in bathing, acute-care hospitalization, and improvement in toileting. To see the advertisements that CMS is placing nationally, go to www.cms.hhs.gov/quality/hhqi. You also can choose the link to the Home Health Compare web site to see how consumers will view your agency's scores as compared to local and national benchmarks. ▼

FDA approves new Alzheimer's drug

The Food and Drug Administration has approved memantine, a drug sold in Germany for many years, as the first treatment designed specifically for late stages of Alzheimer's disease

U.S. marketer Forest Laboratories will sell memantine here under the brand name Namenda, for patients with moderate to severe Alzheimer's symptoms. A Forest spokesperson says the drug should be available in January.

While some patients given memantine experience improvement in memory and thinking skills, the majority of Alzheimer's patients will experience a slower pace of deterioration, letting patients maintain certain functions a little longer. For example, the drug helped some patients maintain the ability to go to the bathroom independently for six more months, according to studies, a benefit caregivers consider important.

Memantine is the first option for advanced stages of Alzheimer's. The nation's four other Alzheimer's medications — Aricept, Exelon, Reminyl and Cognex — work in early stages of the disease.

About 4 million Americans have Alzheimer's, and a million of them are believed to suffer severe symptoms. ■